Ontario

Ministry of Health and Long-Term Care
Long-Term Care Homes Division
Long-Term Inspections Branch

Ministère de la Santé et des Soins de longue durée
Inspection de soins de longue durée
Division des foyers de soins de longue durée

Order(s) of the Director (Amendment)

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public
Name of Director:	
Order Type:	☐ Amend or Impose Conditions on Licence Order, section 104 ☐ Renovation of Municipal Home Order, section 135 X Compliance Order, section 153 ☐ Work and Activity Order, section 154 ☐ Return of Funding Order, section 155 ☐ Mandatory Management Order, section 156 ☐ Revocation of Licence Order, section 157 ☐ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	
Original Inspection #:	2019_610633_0005
Licensee:	Corporation of the County of Bruce 30 Park Street, Walkerton, ON
LTC Home:	Brucelea Haven Long Term Care Home 41 McGivern Street West, Walkerton, ON
Name of Administrator:	Willy Van Klooster

Background:
Ministry of Health and Long-Term Care (MOHLTC) Inspectors conducted a follow-up inspection (2019_610633_0005) at Brucelea Haven Long-Term Care Home (LTC Home) on the following dates: March 26-29, April 1-5, 15-18, 23-26, 29-30 and May 1-3, 2019. During this inspection, the inspectors determined that the Licensee, Corporation of the County of Bruce, failed (Licensee) to comply with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA or Act).

In accordance with paragraph 4 of s. 152(1) of the LTCHA, a referral to the Director was made following a written notification and compliance order being issued for the licensee's non-compliance under s. 31(3) of Ontario Regulation 79/10 (Regulation) under the LTCHA. The written notification and compliance order specifically relate to the staffing plan and the failure of the Licensee to provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and the Regulation. This is the third consecutive time that a compliance order has been issued related to the staffing plan. Previously, a written notification, compliance order and Director's referral were issued on October 26, 2018 during the Resident Quality Inspection (2018_580568_0014) and a written notification and compliance order was also issued on January 9, 2018 (2017_610633_0023) following an inspection.

As a result, and as set out in the grounds below, the Director is issuing a compliance order pursuant to s.153(1) of the LTCHA as the Licensee was not in compliance with subsection 31(3) of the Regulation, as it failed to have a staffing plan that provided for a staffing mix that was consistent with resident's assessed care and safety needs and failed to promote continuity of care. In addition, the licensee was also not in compliance with subsection 18(1) of the LTCHA, as it failed to ensure that the programs required under sections 8 to 16, the services provided under those programs complied with any standards or requirements, provided for in the regulations. The Licensee's non-compliance with these requirements has resulted in residents at the LTC home currently being at risk for receiving insufficient nursing and personal care to ensure that the assessed needs and safety of residents are being met.

The Licensee's compliance history identifies that over the past twenty months from the date of this order, three written notifications and compliance orders related to subsection 31(3) of the Regulation have been issued. In addition, five written notifications, five voluntary plans of correction and one compliance order were issued in relation to services provided under the required programs under sections 8 to 16 of the LTCHA. During this time the Licensee additionally had 67 written notifications, 30 voluntary plans of correction, 30 compliance orders and 6 Director referrals.

Order: #001	Corporation of the County of Bruce

To Corporation of the County of Bruce, you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to:
The Licensee failed to comply with subsection 31(3) of the Ontario Regulation 79/10. Subsection 31(3) states:

The staffing plan must,

(a) Provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) Set out the organization and scheduling of staff shifts;
(c) Promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) Include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8(3) of the Act, cannot come to work; and
(e) Be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The Licensee failed to comply with subsection 18(1) of the LTCHA. Subsection 18 (1) states:

Every Licensee shall ensure that the programs required under sections 8 to 16, the services provided under those programs and anything else required under those sections comply with any standards or requirements, including outcome measures, provided for in the regulations.

Order:

The licensee must be compliant with s. 31(3) of O. Reg 79/10 and s. 18 (1) of the LTCHA.

Specifically, the Licensee shall,

1) Ensure that the staffing plan meets the requirements set out in the Act and the regulation, including providing for a staffing mix that is consistent with residents' assessed care and safety needs, and promotes the continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident, and that there is sufficient staff to implement the home's staffing plan.

2) Bring in a consultant from an external company with extensive experience in managing or operating LTC homes to:

   a) Conduct a review of the following areas and make recommendations for improvement regarding the following:

      - The staffing plan for the organized program of nursing services and personal support services. The review shall include, but not limited to an evaluation of the staffing mix identified in each home area to ensure that the staffing mix is consistent with the assessed care and safety needs of residents' in that home area,

recommendations to promote continuity of care, how to attract and retain personal support workers and registered staff and evaluation of the back up plan for when nursing and personal support staff cannot come into work.

- required programs and policies as set out in the Long-Term Care Homes Act, 2007 (LTCHA), s. 8 - 16 and O. Reg 79/10, s. 48. The review shall include, but not limited to, an evaluation of the LTC home's required programs and make recommendations for improvements to the programs including its education component.

- Upon completion of the review, the consultant will provide both the licensee and the Director under the Act, a report that sets out how the review was conducted, the findings and recommendations for the required programs. This review, findings and recommendations must be finalized no later than **November 15, 2019.**

- Within two weeks of receiving the report from the consultant, the licensee will submit a plan to the Director identifying the recommendations that will be implemented and the timelines for implementation. That plan will be reviewed by the Director and may require changes based on the Director's review of the report and the plan submitted by the licensee. Upon approval of the plan by the Director, the licensee will implement the actions identified.

b) To provide coaching and mentoring support to the Administrator and Director of Care(s) at Brucelea Haven Nursing Home:

- The Licensee will submit a plan to provide coaching and mentoring support to the Administrator and Directors of Care at Brucelea Haven Nursing Home related to staffing, including how to retain staff, planning for staffing issues and ensuring and sustaining compliance with the standards and requirements for the programs required under sections 8-16 of the LTCHA. This coaching and mentoring will support the Administrator and Director of Care to achieve compliance with the specific areas of non-compliance identified and ensure that they have the knowledge and skills to sustain that compliance.

- The plan will include the areas to be covered in the coaching and mentoring, timelines for the coaching and mentoring, and a report at the end of the mentoring period confirming the areas identified have been covered. The areas covered are to include at a minimum, a detailed overview of the LTCHA and Regulation 79/10, with a focus on the current non-compliance identified in this Order, the requirements of outstanding Inspector and Director's Orders and areas of non-compliance identified in recent inspections.

The plan is to be submitted to Stacey Colameco, Director, by fax to 1-416-327-7603 or courier to 1075 Bay Street, 11th Floor, Toronto, Ontario M5S 2 B1 by **November 15, 2019.**

Grounds:

This Order is being issued to ensure that the licensee achieves compliance with the serious and on-going non-compliance identified below by taking the actions identified by the Director in this Order, in addition to the actions identified by inspectors in the compliance orders issued in Inspection #2019_610633_0005.

Specific evidence of the non-compliance identified, and that is relied on by the Director, is contained within the follow-up inspection report noted below as well as in other inspections listed in the compliance history described below in this Order.

June 11, 2019 (2019_610633_0005): A follow up inspection was conducted on March 26-29, April 1-5, 15-18, 23-26, 29-30, May 1-3, 2019. The Licensee failed to comply with CO #003 from Inspection 2018_580568_0014 served on the licensee on October 26, 2018, with a compliance due date of February 22, 2019. CO #006 and Director Referral #003 was issued in relation to O.Reg. 79/10, s. 31 (3). It was determined that the licensee failed to ensure that a staffing plan provided for a staffing mix that is consistent with the residents' assessed care and safety needs and that met the requirements set out in the Act and Regulation as the Licensee consistently had a staffing shortage at the LTC home.

The document, County of Bruce HR Indicators-Nursing Hours Overtime by date and employee from January 25 to March 27, 2019 (60 days), showed that 80 employees (nursing staff) worked 2512.30 hours of overtime (equivalent to 314 eight-hour shifts). Despite the overtime by all disciplines, which included staying late and double shifts, the home was unable to maintain their staffing plan levels for RNs, RPNs and PSWs. Three RPNs and three PSWs said that there was a strain on staff, and that overtime and double shifts were worked constantly.

Human resource specialist #154 said that there should be 288 hours of PSW work completed daily. The "County of Bruce HR Indicators-All nursing hours worked" dated from January 25 to March 27, 2019 (60 days) showed that on 57/60 days (95 percent), the home did not have the full complement of PSW staff despite the overtime worked by PSWs daily.

The Nursing Staff Vacancy Status Report as of April 5, 2019 stated that three permanent part time (PT) PSW positions and eight temporary PT non-permanent positions were not filled including three PSWs, one RPN and four RNs. There were no full-time positions being recruited. Human resource generalist #124 stated there were no applicants however, review of the job postings online and related documentation provided by human resources showed that advertising was not completed as outlined in the home's recruitment plan. The Administrator agreed that the home was short PSWs on 57/60 days (95 percent) during the identified time period and they acknowledged that staff were working overtime to compensate.

The staffing shortages impacted resident care in the following areas:

A) Transfers:
Instead of the assessed two-person assist requirement for transfers, residents are being transferred by one person. Three improper transfers resulted in significant injuries to one resident. A short time later the resident passed, and it was noted on the death certificate that falls with injury were a contributing factor. During the inspection, staff were observed transferring independently and staff interviewed stated that there were times they were the only PSW on the unit of 24 residents which impacted the assessed care provided to residents related to transfers. The A-DOC said one-person transfers occurred because of the lack of staff at the home.

B) Twice weekly bathing according to assessed preference;
Record review of the plan of care for four current resident's and staff interviews were completed related to bathing. Four of four residents did not receive their baths twice weekly. The general staffing plan was two PSWs plus a bath person. If the home was short, the PSW struggled to get all the residents up or back into bed and there was no time for bathing. RPN #142 said while they tried to make bathing a priority, it required pulling staff from the floor to do the baths which left only one PSW to provide care to all 24 residents. The DOC acknowledged that bathing was missed and agreed that bathing was not the priority when working short staffed. The County of Bruce Daily Schedule Listings dated from January 25 to March 27, 2019, stated that on 34/60 days (57%), the home did not have the PSW shifts filled that were dedicated to bathing.

C) Toileting routines;
Record review of the plan of care for three resident's and staff interviews were completed related to toileting. Three of three residents did not receive toileting/continence care per their assessed needs and plan of care. Staff said the impact to residents for toileting when the home was short of staff was residents were left sitting in a soaked brief and/or had to wait longer for assistance to be toileted. They said that some residents were put to bed early and they were not checked again for changing briefs and repositioning when they worked short staffed.

D) Repositioning and monitoring;
Record review of the plan of care for three resident's and staff interviews were completed related to repositioning. Three of three residents were not repositioned as per their assessed needs and care plan. Staff all said that when there was only one PSW staff and a resident required two staff to reposition their repositioning was sometimes not completed. They also said that residents would have to wait while staff sought help from another staff member. At times this staff member had to come from another RHA. Registered staff also said the impact of working short related to repositioning was that residents would sit or lie longer in one spot which would increase the potential for skin breakdown.

E) Oral care;
Observations and interviews showed that four of four residents did not receive oral care twice

daily before breakfast and before their bed time as required. Three PSWs all said that oral care should be completed twice daily before breakfast and bed time and this was not done because of the staffing shortages at the home.

F) Assistance at all meals;
Observations and staff interviews showed that seven residents did not receive the assistance they required for meals. A staff member said that when the home was short an RPN and they had to work both sides (one to 48 residents), the RPN was unable to assist in the dining room for meals. When asked what the impact of working short had on feeding, the PSW said that residents did not get a full meal. Residents got what they could, enough time was not given, and some residents waited to eat. The staff member explained that residents that were not cognitively aware were impacted the most. They did not receive the assistance and time they required to eat. The meal was often cold by the time it was served. The staff member explained that residents fell asleep waiting and therefore did not eat or drink as well. Staffing was the biggest issue at the home and they relied on family for feeding residents at meals.

G) Timely medication administration;
Observations, record review of the plan of care for three resident's, and staff interviews were completed related to timely medication administration. Three of three residents received their time sensitive medications late and not as prescribed. Registered staff said that when working short they had 48 residents to give medications to, residents had to wait, and medications were late. They also said that the risk of medication errors increased when working short staffed. The RAI Coordinator said there were times where there was only one PSW and one RPN on the unit. They said they were pulled from their RAI-Coordinator role to fill the RPN spot and the RPN would fill the PSW role.

H) Completion of Minimum Data Set (MDS) assessments;
Staff interviews, RAI-MDS assessments for three identified residents and the home's related MDS reports showed that the RAI-MDS assessments were not completed per the Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN). The completion of RAI-MDS assessments was impacted by inconsistent staffing, RPN staff working one to 48 residents, clinical care coordinator and RN support role vacancies, and the RAI-Coordinator, and RN support role staff being pulled to work the floor due to insufficient staffing. Resident assessment protocols and resident care plans were not up to date.

I)Assessments for altered skin integrity;
Record review of the plan of care for three resident's and staff interviews were completed related to the completion of weekly skin and wound assessments. Three of three residents did not receive weekly skin and wound assessments as required. Registered staff said that wound treatments, wound care and dressings were missed when working short.

J) Authorization for admission;
Two residents were denied admission to the home and one resident was denied returning to the

home. The reason provided was related to the lack of staff at the home that was required to provide the care the resident's needed.

In addition, the licensee failed to ensure that the home's staffing plan mix promoted continuity of care by minimizing the number of different staff members who provided nursing and personal support services to an identified resident. This became evident with a situation where a resident was cared for by registered staff that were not familiar with the resident, had not completed their orientation to the home, and had never worked on the unit the resident resided on. When there was change in condition, the registered staff did not consider the resident's previous history and diagnoses resulting in the incorrect processing of orders. It was not until the regular scheduled registered staff came back on duty a few days later that the resident was assessed, and an alternate diagnoses and treatment implemented. This registered staff was familiar with providing care to the resident and recognized that the resident was exhibiting signs of a different diagnoses.

The centralized scheduling system and staff shortages did not promote the continuity of care by minimizing the number of different staff members who provided nursing and personal support services to each resident. Call outs for shifts were by designation and did not include the home area. Staff said when they worked, and there were call ins to another home area, they pulled them to work that area. A registered staff said that RPNs were placed wherever there was a hole, and this may not be their home area. An RPN and the RAI-Coordinator said that staffing at the home was not good, there was not enough staff and nights and weekends were "brutal". Staff said they were called constantly to pick up shifts and staff were switched around on the home areas last minute. A number of staff said that the home's staffing system lacked continuity in providing resident care as staff were not familiar with the residents.

Management Issues:

Observations, staff interviews, and human resource reports at the time of the inspection showed that the previous DOC and Nurse Consultant were no longer at the home. One DOC position was filled on an interim basis by the ADOC however, they had been removed from their Clinical Care Coordinator (CCC) role. The CCC role was vacant. The Nurse Consultant returned to assume one DOC role on May 3, 2019. The second DOC position was vacant. The A-DOC lacked support, experience and training in the role. Observations and staff interviews showed that one RN support role was unfilled. The current RN support staff was pulled to the floor to cover shifts in addition to their role on a regular basis. A RN said that the RN support role was intended to float throughout the home to buffer days and evenings however, due to staff shortages they were pulled to work the floor on a regular basis in addition to trying to fulfil the responsibilities of their position. HR reports and staff interviews showed that the A-DOC was not always present at the home in their capacity as A-DOC. They also worked floor shifts to ensure that there was 24/7 RN coverage. There was not always a RN working at the home. Initially, the Administrator said they were not aware of any time where there was no registered nurse in the building but later said that they may have recalled a few times. The A-DOC shared that they were placed in this role on a temporary basis without training and support. The Administrator said that the primary concern

was that there were no senior staff at the home. There should be two DOCs and there were not. The Administrator also said that the CCC role was not getting done and they agreed that the RAI-Coordinator and RN support role were being pulled to work the floor when the home was short staffed. The Administrator stated that staff did not have the senior nursing support.

The home's annual evaluation of the staffing plan dated December 2018 stated that the PSW staffing plan would address five care areas; bathing, toileting, repositioning, oral care and assistance at meals, however, this was not implemented. The annual staffing plan evaluation stated that the registered staffing plan would address two care areas; timely administration of medication and skin audits for new residents however, neither of which were implemented. The plan of care for identified residents, the home's related documentation, multiple staff of all disciplines at the home, the supervisor scheduling, the A-DOC and the Administrator all said that the home's current staffing mix and staffing shortages did not promote continuity of care and did not ensure that there were enough direct care staff/hours to meet the residents assessed care and safety needs. This included leadership supports, transfers, twice weekly bathing, toileting routines, repositioning and monitoring, oral care, assistance at all meals, timely medication administration, completion of MDS assessments and weekly assessments for altered skin integrity, documentation, admissions/discharge, orientation and palliative care.

Programs:

The licensee has failed to ensure that the services provided within the programs required under sections 8 to 16 of the Act complied with the standards and requirements provided for in the Regulation. During a two-month period from January 25, 2019 to March 27, 2019 there were five full shifts and two partial shifts where there was no registered nurse in the home. Support for front line care staff was not present which posed a potential risk to all residents in the home.

The organized program of nursing services for the home did not meet the assessed needs of residents. Residents identified with altered skin integrity did not receive weekly skin assessments by a registered staff member as directed by the Regulations and the residents were not repositioned as directed by their plan of care. Residents that were to be administered time sensitive medications for pain, responsive behaviours and Parkinsons Disease received their medications late. Where there should have been one RPN to administer medication to 24 residents on each of two home areas, there was just one RPN to administer medication to 48 residents. The RPN was unable to administer medication as prescribed.

The organized program of personal support services in the areas of oral care, bathing and transfers did not meet the assessed needs of the residents. Four of four residents reviewed were identified as not having received their oral care as per their assessed care needs and according to the regulations s. 34. (1) which states that each resident of the home is to receive oral care to maintain the integrity of the oral tissue that includes mouth care in the morning and evening, including the cleaning of dentures. Four of four residents reviewed were identified as not having been bathed according to their assessed needs and according to the regulations s. 33. (1) which

states that residents are to be bathed at a minimum twice a week according to their preference. For one resident it was documented that over a 30-day period the resident was only bathed on one occasion, for another resident they went seven days without being bathed. It was identified that residents were not being transferred according to their assessed care and safety needs. One particular resident was transferred on three separate occasions with just one staff when their plan of care identified that they were two-person extensive assistance. The resident sustained injuries on each of the three occasions and died within a short time of their last injury.

The organized program of nutrition care and dietary services did not meet the daily needs of the residents. Observations conducted by inspectors during a meal identified seven residents that did not receive their required assistance with eating. In some cases, the residents waited long periods for assistance at which point their food was cold and in other cases meals were removed before the assistance was provided.

The evidence gathered in this inspection demonstrates that despite the Orders issued on October 26, 2018 and detailed below, the licensee had failed to act on the Orders of the Inspector and there were repeated areas of non-compliance related to the staffing plan providing for a staffing mix that is consistent with residents assessed care and safety needs, and services within programs required under section 8 to 16, meeting the requirements set out in the Act and Regulation.

Compliance History: Previous inspections where s 31(3) the staffing plan was issued.

October 26, 2018 (2018_580568_0014): A resident quality inspection was conducted on August 28, 29, 30, 31, 2018; September 4, 5, 6, 7, 10, 11, 12, 13, 14, 16, 17, 18, 19, 20, 21, 24, 25, 2018. The Licensee failed to comply with CO #003 from inspection #2018_580568_0014, served on the licensee October 26, 2018, with a compliance due date of February 22, 2019. CO#006 and Director Referral #003 was issued in relation to the Regulation, s. 31 (3) The licensee failed to ensure that a staffing plan provided for a staffing mix that is consistent with residents assessed care and safety needs that meets the requirements set out in the Act and Regulation.

Several complaints/concerns were received by the MOHLTC in relation to staffing shortages:

- Complaint IL-57691d-CW submitted July 3, 2018, in relation to shortage of staff affecting residents' care and the Residents' Bill of Rights.
- Complaint IL-58324-CW submitted July 23, 2018, related to significant staffing shortages that were negatively impacting resident care such, as falls and call bells not being answered.
- Complaint IL-58328-CW submitted July 23, 2018, related to dining and snack service, short staffing, bathing and falls prevention.
- Complaint IL-58551-CW submitted July 30, 2018, related to a resident not receiving baths as scheduled.
- Concern received by the Patient Ombudsman on August 1, 2018 and forwarded to the

MOHLTC, related to bathing, short staffing and infection control.

On September 4, 2018, a staff member told Inspector #137 that staffing shortages in the home were critical and had been since January 2018. Resident care had been affected as residents did not always receive baths, mouth care, and toileting consistent with their assessed care needs. Between August 31 and September 3, 2018, there were no baths completed. Several staff have quit, including long-term employees due to the heavy workload from working short, and newly hired staff did not stay. Part-time staff were being maximized to full-time leaving no part-time staff to draw from. A staff member said there was no support or assistance from the Administrator or Director of Care which was very frustrating as staff were exhausted.

In interviews with multiple staff they shared that residents were not always receiving baths, oral care, toileting, food served hot, nourishments, and staff were using lifts independently during transfers. If residents or family members complained to management, those residents received their bath. The part-time staff were working full-time hours so there were no staff available for call-ins. Many staff were working double shifts and were exhausted. There was no support from the management in the home and they were not visible on the units. The Ward Clerk and Inspector #137 reviewed the daily assignment sheets from July 1 to August 31, 2018. There was documented evidence that on 58 of 62 (93.5 per cent) days the home was without the full complement of PSW's, with one or more PSW shifts not filled on those days, as well as some registered staff vacancies. There was a RN Support Role position, but the individual had been off on Medical Leave and had not been replaced. The Assistant Director of Care and Clinical Care Coordinator positions were vacant.

On September 10, 2018, the Ward Clerk said staffing had not been so "critical" as it was now. Many staff work overtime and double shifts to ensure coverage, but they were exhausted and worn out. They tried to "catch up" on missed baths but, for the most part, it did not happen. Inspector #137 reviewed bathing records which showed 14 of 141 (9.9 per cent) residents received all nine of their scheduled baths in July and 11 of 138 (7.9 per cent) residents received all nine of their scheduled baths in August 2018.

A RN expressed their concern that chronic staff shortages was having an impact on resident care. On three south there were at least five residents with wounds now where there used to be none. This was in part because there was not sufficient staff to turn/reposition residents as often as needed. Falls in the home have increased because staff were not able to monitor residents as closely. They stated they tend to be reactive and not proactive in preventing falls. The RAI-Coordinator provided the falls list for July and August 2018, which indicated there had been 111 falls over the two-month period.

A PSW shared that there were two incidents in one month, where they were working short on the secure unit during the night shift. A resident, who exhibited responsive behaviours including physical aggression and wandering, was observed going into other resident rooms. The plan of care for the resident recommended that two staff provide care for the resident, or one staff with

another just outside of the room.

On both nights in question they were the only staff on the unit and were cornered in another resident's room by the identified resident. They had difficulty accessing their phone to request help from the staff member on the adjacent unit, which posed a potential risk to the residents in the rooms and the PSW.

During an interview with a RN they shared that on a specified date during the night shift they were alerted to an intruder in the home. Another registered staff said they received a call to their phone that it was the police and they were at the front door. They explained that they were looking for an individual who they thought might be on the premises. The staff said they were short two PSWs that night.

On this shift two registered staff were pulled to work the floor because of the PSW shortage. In an interview with one PSW they shared that they were working a double shift because of staff shortages. Originally, they were going to leave early but they did not want to leave another PSW on their own to provide care for 48 residents, as it was their first shift on their own after completing their orientation and they had not done any orientation on the floor they were currently assigned.

During an interview with another staff they said they worked nights on a specified floor on the night the intruder was in the building. They were the only PSW on the floor for 48 residents and the RN had told them they would help with rounds. When they went to start rounds the RN was not around, so they started on their own and assumed that RN was busy. The PSW shared that there were many residents on third floor that required two staff to change and reposition in bed. One resident was a heavy wetter and usually needed to be changed two to three times on nights with assistance of two staff, however they only got them changed once on this night shift. The same resident was also to be turned and repositioned every two hours and the PSW said that was not done. The staff member said that they barely had time to do basic cares and answer call bells. The RN shared that they did not check all of the doors that night because they were so busy due to staffing shortages. If they would have had time to check all the doors in the home, which was their normal practice, the intruder may have been prevented from entering the home.

In an interview with the Administrator the Inspectors asked if they were aware of the staffing shortages for the upcoming weekend. The Administrator said they were using Centralized Scheduling and would receive an alert on Thursdays. The Inspector said the Ward Clerk was off on Thursday and Centralized Scheduling only replaced one half RPN shift. The Inspector explained to the Administrator that combined, there were fourteen unscheduled shifts for Saturday and Sunday. The Administrator did not respond when asked by the Inspector what the staffing plan was for the weekend.

An Inspector spoke with a resident who indicated that they had been left in pain on a specified date. When staff came to assist the resident with dressing around 1000 hours the resident asked them for their medication to keep pain under control. The resident said that the medication was

not brought until 1045 hours and by that time they were going crazy with pain. In an interview with the registered staff working that shift, they recalled being short an RPN on the floor. They also remembered the resident being very upset because the staff member was more than thirty minutes late with their medication. The resident was shaking and expressed that they were in a lot of pain. The RPN apologized for being late and explained that they had to give medications on ends of the unit, 48 residents, because of staff shortages. In these situations, it is almost impossible to give all medications at their scheduled times. Review of the employee schedule listing for the identified date showed that there was only one registered staff working on the specified floor that day.

The licensee had failed to provide for a staffing mix that was consistent with residents assessed care needs and that met the requirements set out in the Act and this Regulation.

January 9, 2018 (2017_610633_0023): A resident quality inspection was conducted on November 6-10, 14-17, 20-24, 2017. CO #003 was issued with a compliance due date of March 30, 2018, in relation to the Regulation, s. 31 (3) The licensee failed to ensure that a staffing plan provided for a staffing mix that is consistent with residents assessed care and safety needs that meets the requirements set out in the Act and Regulation.

An anonymous complaint IL-52279-LO/Log #018374-17 was submitted to the MOHLTC on August 8, 2017. The complainant stated that the home was short staffed and that residents did not receive their baths. A Resident stated that "when there is a shortage of staff, I will miss my bath. I missed it about two weeks ago." In another interview a resident stated they "had to fight to get their bath on a Friday". The resident explained that they go home on the weekends and it stressed them out when the bath person does not come to work that day as they worried about getting a bath before they go home. The resident also said related to bathing that it was bad for those residents that can't speak for themselves. A third resident said that they had concerns about missing their baths. The resident stated that they often missed their Saturday bath and in October 2017 there were three occasions that they were not offered another bath. If the floor was short, it was the bath PSW that was pulled to work the floor rather than to administer the resident baths. In an interview with a registered staff they stated that this particular resident writes their missed baths down and they had missed five out of seven of their baths recently.

The Ward Clerks explained that when staff call in they tried to call a staff to work for the same day or the next day in order to cover the missed baths. A Ward Clerk stated that the floors would call them to let them know who missed their baths and that there was no official documentation for tracking missed baths. Both Ward Clerks stated that the weekends were the worst for staffing and agreed that there have been residents lately that have missed their baths.

A registered staff said that the residents that have baths scheduled on the weekends would often miss their baths and that this was a real issue. They also said that missed baths were not documented and that many residents have missed their baths for days. When asked how the shortage of PSW staff impacted resident care, the registered staff replied that it impacts in every

way. Everybody does their hardest, residents wait longer, eight out of my last ten shifts we were short staff and it is not possible to get everything done. The registered staff also stated that residents that were able to complain would get their baths before residents that can't speak for themselves.

The staffing schedules from August 1 to 31 and 2017, and September 1 to 15, 2017, that were provided and calculated by Ward Clerk #123, documented that on 22/46 days the home was without full complement of PSW staff (48 percent) with one or more PSW shifts not filled on those days. Administrator #101 said that baths have been an issue lately and they had thought they were doing better but in the last three months they had slid back. The Administrator explained that they currently had 15 PSW lines not filled with some coverage from casual staff.

The licensee has failed to provide for a staffing mix that is consistent with residents assessed care needs and that met the requirements set out in the Act and this Regulation including that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice.

In the last five inspections dating back to November 2017, Ministry Inspectors have issued multiple findings of repeated non-compliance including 39 written notifications, 21 voluntary plans of correction and 15 compliance orders prior to the latest follow up inspection initiated on March 26, 2019, which resulted in 31 written notifications, 9 voluntary plans of correction, 18 compliance orders, and 5 Director referrals.

Additional compliance orders issued June 11, 2019 (2019_610633_0005):
The Licensee failed to comply with CO #007 from inspection #2018_580568_0014, served on the licensee October 26, 2018, with a compliance due date of January 3, 2019. CO #008 and Director Referral #001 was issued in relation to LTCHA, s. 23. (2) The licensee failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). The outcome of an investigation related to the alleged verbal abuse of a resident by a staff member was not reported to the Director and the critical incident system was not amended.

The Licensee failed to comply with CO #001 from inspection #2018_580568_0014, served on the licensee October 26, 2018, with a compliance due date of January 3, 2019. CO #007 and Director Referral #001 was issued in relation to LTCHA, s. 23. (1) The licensee failed to ensure that, every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations. Three allegations of abuse/improper care that the licensee knew of were not immediately investigated as required.

The Licensee failed to comply with CO #002 from inspection #2018_580568_0014, served on the licensee October 26, 2018, with a compliance due date of January 3, 2019. CO #002 and

Director Referral #002 was issued in relation to LTCHA, s. 24. (1) The licensee failed to ensure that when a person had reasonable grounds to suspect that improper care of a resident that resulted in harm or risk or harm to a resident occurred, suspicion and the information it was based upon was reported to the Director immediately. One incident of alleged sexual abuse and one incident of alleged improper care were not immediately reported to the Director.

CO#012 and Director referral #004 was issued in relation to the Regulation, s. 36. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. Observations and interviews with staff showed that staff were transferring a resident who required two person transfers independently. The resident requiring two- person transfer was transferred by one person on three separate occasions sustaining injuries after each transfer.

The Licensee failed to comply with CO #004 from inspection #2018_580568_0014, served on the licensee October 26, 2018, with a compliance due date of, January 3, 2019. CO #013 and Director Referral #005 was issued in relation to the Regulation, s. 50. (2) The licensee failed to ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented; is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; and any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

A resident, who exhibited pressure ulcers, was not assessed by the RD and reassessed at least weekly by a member of the registered nursing staff. The resident was not repositioned every two hours when asleep as clinically indicated. A resident, who exhibited multiple skin tears and a pressure ulcer, was not reassessed at least weekly by a member of the registered nursing staff. The resident was not repositioned every two hours as required to relieve pressure. The skin and wound assessments showed that the pressure ulcer had worsened during the specified time period.

CO #001 was issued in relation to LTCHA, s. 8. (3) The licensee failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. Schedules showed that there was no RN for the full shift for seven shifts identified in a 60-day period. In combination with the lack of nursing leadership (two vacant DOC positions at the time) and reduced staffing levels this contributes to the care concerns identified in sufficient staffing.

CO #003 was issued in relation to LTCHA, s. 101. (3), The licensee failed to ensure that as a

condition of their licence that the licensee comply with the Act, the Local Health System Integration Act, 2006, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. The licensee has failed to comply with the Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN). The LSSA stated that the licensee was required to meet the practice requirements of the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) system however, the Long-Term Care Home failed to meet the practice requirements.

CO #004 was issued in relation to the Regulation, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act; and was complied with. The licensee failed to ensure that their skin and wound policy was compliant with legislation in relation to completing assessment for all areas of altered skin integrity including bruises, skin tears and stage I pressure ulcers and that the medication policy included a process to review quarterly medication incidents. The licensee also failed to comply with the medication policy in relation to investigating, documenting and analyzing medication incidents; and complying with the falls policy in relation to completing head injury assessments for specified falls.

The Licensee failed to comply with CO #005 from inspection #2018_580568_0014, served on the licensee October 26, 2018, with a compliance due date of January 3, 2019. CO #005 and was issued in relation to LTCHA, s. 19 (1), The licensee failed to protect residents from abuse by anyone and that residents were not neglected by the licensee or staff.

A resident requiring two-person transfer was transferred by one person on three separate occasions and each time sustained an injury. A short time after the last injury the resident passed, and it was noted on the death certificate that falls with injury were a contributing factor.
A resident crying out in significant pain was left unattended with no interventions initiated to relieve the pain, the resident fell and sustained an injury as a result. The licensee failed to provide the resident with treatment, care or assistance for their health, safety and well-being.

CO#008 was issued in relation to LTCHA, s. 44. (7) The licensee failed to review the assessments and information that were required to have been taken into account under subsection 43(6) and approve the applicant's admission to the home unless the home lacks the physical facilities necessary to meet the applicant's care requirements; the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or circumstances exist which are provided for in the regulations as being a ground for withholding approval.

The licensee did not lack the physical facilities necessary to meet the resident's care requirements and staff of the home did not lack the nursing expertise necessary to meet the residents care needs. There were no circumstances which were provided for in the regulations for withholding approval for their admissions to the home.

CO#010 was issued in relation to the Regulation, s. 33. (1) The licensee failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. Sample of four residents for a one-month period showed that the residents did not receive two baths per week and they missed anywhere from 12 and 88 per cent of their baths that were scheduled.

CO#011 was issued in relation to the Regulation, s. 34. (1) The licensee failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, mouth care in the morning and evening, including the cleaning of dentures. Sample of four residents where oral care for each of the resident was not being provided as per the resident's assessed care needs. For two of the residents this occurred between 80 and 90 per cent of the time. Staff stated that they are lucky to complete oral care once a day and rarely twice as required.

CO #014 was issued in relation to the Regulation, s. 73. (2) The licensee failed to ensure that, no person simultaneously assists more than two residents who need total assistance with eating or drinking; and no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.
Observation of meal service showed that seven residents requiring total assistance with eating or drinking did not receive the required assistance for their meals and that staff assisted more than two residents at a time. Observations also showed that residents who required assistance were served a meal prior to someone being available to provide assistance.

CO #015 was issued in relation to the Regulations. 148. (2) Before discharging a resident under subsection 145 (1), the licensee failed to ensure that alternatives to discharge have been considered and, where appropriate, tried; in collaboration with the appropriate placement coordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; and provide a written notice to the resident, the resident's substitute decisionmaker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

The licensee failed to ensure that before discharging an identified resident, alternatives to their discharge had been considered and tried in collaboration with the appropriate placement coordinator and other health service organizations. A written notice to the resident and/or the resident's substitute decision-maker (SDM) that outlined the supporting facts as they related to the resident's condition and justified the licensee's decision was not provided.

CO #016 was issued in relation to the Regulation, s. 131. (2) The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the

prescriber.

The licensee failed to ensure that a drug for two identified residents was administered in accordance with the directions for use by the prescriber and that drugs, including time sensitive medications to treat pain, behaviours and Parkinson's related symptoms, were administered to residents in accordance with the directions for use specified by the prescriber.

The Licensee failed to comply with CO #006 from inspection #2018_580568_0014, served on the licensee October 26, 2018, with a compliance due date of, February 22, 2019. CO #017 was issued in relation to LTCHA, s. 6 (1)(c), s. 6 (10) (b) and s. 6 (7). The licensee failed to ensure that there was a written plan of care that set out clear directions to staff and others who provided direct care to the resident; that the plan of care was reviewed and revised when the resident's care needs changed, and that care set out in the plan of care was provided to the resident as specified in their plan of care.

The licensee has failed to ensure that the written plan of care for an identified resident sets out clear directions to staff who provided direct care to the resident related to the resident's transfer status.

The licensee has failed to ensure that a resident's plan of care was revised with respect to continence care management when the resident's care needs changed. The licensee failed to ensure that interventions related to continence for four residents was provided to the residents as specified in their plans of care.

CO #018 was issued in relation to LTCHA, s. 76. (2) The licensee failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

The licensee failed to ensure that all registered staff had received orientation training before performing their responsibilities, including policies of the licensee that were relevant to the staff's

responsibilities, and any other areas provided for in the regulations.

The inspectors' analysis of the compliance history associated with the non-compliance identified along with the evidence gathered in the follow up inspection, I have determined that a Director's Order is warranted given the Licensee's non-compliance with s.31 (3) of the Regulation related to the staffing plan failing to provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and Regulation and the licensee's compliance with s. 18(1) of the LTCHA.

The Licensee's history of repeated and ongoing non-compliance with the requirement under the regulations continues to occur at Brucelea Haven Long Term Care Home. The decision to issue this Director's Order was based on the LTC home's compliance history over the past 18 months.

The home had a level 5 history as they had on-going non-compliance with this section of the LTCHA that included:
Compliance Order #003 issued January 9, 2018 with a compliance due date of March 30, 2018 (2019_781729_0005)
Compliance Order #006 issued October 26, 2018 with a compliance due date of February 22, 2019. (2018_580568_0014)

At the request of the Director, Brucelea Haven submitted a plan of corrective action from inspection 2018_580568_0014 to the Director January 4, 2019 that outlined steps to come into compliance with outstanding compliance orders however, the LTC home failed to implement the corrective action plan. Given the repeated non-compliance with Orders and Director's Referrals at this home, the lack of understanding exhibited to ministry inspectors with respect to requirements under the LTCHA and the actions needed to address the non-compliance, it is necessary to ensure the leadership team at the home is well positioned to ensure the care and safety of residents in the home. The Executive Director does not have a clinical background and at the time of the follow up inspection both DOC positions were vacant as were several of the nursing support positions. The leadership team has not been effective in bringing the home into compliance and with the onboarding of new nursing leadership in the home, it is the Director's belief that the licensee needs help to determine how to achieve and sustain under the LTCHA and Regulation with respect to the non-compliance identified in this Order.

The Licensee has failed to ensure that the home's staffing plan provided for a staffing mix that is consistent with residents' assessed care and safety needs and meets the requirements set out in the LTCHA and Regulation and have not put strategies in place to effectively comply with the requirements of the LTCHA and Regulations.

The decision to issue this Director's Order was based on the scope and severity of non-compliance, and the LTC home's compliance history over the past 36 months. The scope is identified as widespread in the LTC home and represents systemic failure that affects or has the potential to negatively affect a large number of the LTC home's residents. The severity is

determined to be actual harm or risk of actual harm. The Licensee's history of repeated non-compliance; despite Written Notifications and Compliance Orders, repeated and ongoing non-compliance with requirements under the LTCHA continue to occur at Brucelea Haven Nursing Home.

This order must be complied with by:	February 15, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M6S 2T6

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
1075 Bay St., 11th Floor, Suite 1100
Toronto ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website.

Issued on this 12th day of July, 2019, amended on July 24, 2019.	
Signature of Director:	
Name of Director:	Stacey Colameco

Version date: 2017/02/15